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Our Approach to "Costing" the Standards

Background:
The Standards for Public Health in Washington State describe what we believe everyone has a right to expect of the governmental public health system. They were developed jointly by state and local public health officials and were field tested over time. A baseline study conducted in 2002 measured the capability of the state agency and 34 local public health agencies to meet the standards. The Baseline study shows how far we are from being able to perform the Standards statewide.

Sub-Committee Objective:
The purpose of this sub-committee is to develop a way to estimate what it would cost to fully achieve the Standards statewide. The Subcommittee will be formed by drawing on people from both the Finance Committee and the Standards Committee of the Public Health Improvement Partnership.

Basic ideas that underlie our approach:
The Standards are what we believe the state and every local health jurisdiction must be able to do in order to protect and promote the health of people. We chose only a few, important measures for each Standard. The measures are just *indicators* of performance that show whether a Standard is met routinely. The cost of meeting the standards will not rest with the measures themselves, but with the underlying capacity it takes to demonstrate that performance. Achieving a standard will entail costs that go far beyond those few, specific measures. Our cost model will be based on what we actually believe it will take to meet the Standards, including assumptions for personnel, equipment and other normal costs.

Product:
This work will provide a cost model that estimates the additional resources needed to achieve public health performance standards statewide. It will be based on information gathered in the 2000 Field test and the 2002 Baseline Study.

Limitations:
This subcommittee will focus on Cost model work only. "What will it take, financially, to meet the Standards in today's current organization of LHJs and DOH?" This group will not try to figure those costs in any re-structured system. That work could be done as a second step, in concert with others on the Finance Committee.

Discussion of Cost Model Approach
The following assumptions were discussed and agreed upon at the 1/26/04 joint finance and Standards meeting.

Assumptions about the Subcommittee Cost Model work:

1. The stated funding needs will be *estimates*. The estimates will be based on models using known costs such as salary, benefits, rent, equipment and vehicles as well as and cost drivers (i.e. the number of restaurants to be inspected.)

   The models and assumptions will be used to derive reasonable estimates of overall need – but they will not represent the only way or the "right" way to organize or deploy resources.

   Once the basic work is done, further work may be done to estimate costs using different approaches that seem to offer improved service or that promise cost savings.

2. The estimates will focus on the system as a whole. We will estimate state, local and regional needs separately, but we do not anticipate that the model can be applied in a district-specific or service-specific method.

3. The estimates will describe additional capacity needed – this will be *on top of* current capacity in the system. Thus, additional funds needed will be for filling the gap between current performance and the performance we want to achieve to meet the standards.

4. We will decide whether we want to estimate "core" resources needed based on the standards <u>OR</u> include categorical resources when estimating needs. We will look at this to see what is feasible and helpful before adopting the approach.

   Many core services are provided only because categorical programs help support basic capacity. But, the purpose of attempting to separate core from categorical will be to reveal the real cost of core resources that must be in place to assure public health protection. (*Two examples to support this discussion are appended here.)

5. The cost estimates will incorporate the best judgment of practicing professionals, applied using real-life scenarios and costs to develop formulas. These assumptions will be documented and appended so readers can easily track how cost figures were derived.

   We may develop a process that compares our models with performance demonstrated in the 2004. It would show the relationship between what LHJs and DOH have -- and what our formulas or models say they should have.

6. The cost estimates will be calculated per Standard -- and then aggregated by topic for the five areas. Not every Standard must have a cost assigned, though we expect most will. We do not intend to set costs per measure and believe it would be a misrepresentation to do so.

7. Cost models will be scaled for size. Factors may be applied that incorporate different costs for rural or urban areas. (Example: rural areas have greater travel time and fewer appointments per day. Urban areas may have concentrated populations, but also much higher demands for service.) For this model we will use (or adapt) the type of model used in the Baseline Study. The cost models will not factor in any inefficiency that may currently exist in the system.

8. Reports made based on the costing project should lead to next steps, in which we look at ways to improve our public health efforts. We should keep our thinking open to quality improvement – finding ways to be more effective in terms of outcomes and more efficient in terms of costs and resources.

   A separate effort will look at financing the system differently and may make recommendations that use the cost models developed by this group. (The Cost model group will not duplicate this effort.)

9. In later steps, we want to be able to state recommendations for funding priorities in public health and we believe at the outset that our priorities must be tied to the work of the Key Health Indicators Committee and to what we learn about Access to Critical Health Services. In addition, community engagement is a critical part of establishing those priorities.

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*These examples were used while discussion "core" versus "categorical."

Example 1: An urgent disease outbreak (measles) will cause all the nurses and many other staff in a small department to drop their planned activities in order to initiate case follow up, call families, educate providers, start immunization clinics for large numbers of people, distribute vaccine, do media interviews, talk with school officials to enforce admission rules, and many other actions. In most LHJs, these actions are not paid for by any specific fund but are cobbled together from many sources during an intense work effort. What do you need on hand for "core" CD response?

Example 2: Every LHJ should have a basic amount of health education capacity available. How much? Our model would state the assumption. It would be sufficient for "core" – but it will not be adequate to bring down rates of tobacco use… That would take increased, categorically targeted resources.

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Process Steps for Developing Cost Models

Background

- Look at the cost model work done by the prior committee. It was not pegged to the actual Standards. Rather it summarized typical costs in today's public health delivery system.

Developing Costs

- Brainstorm and identify the existing conditions and environment of the public health system for both State DOH and LHJs to put cost estimates in context. Recognize that working toward the Standards is not independent of this environment or delivery system.

- Look at each Standard: What is the "Big Idea" behind that standard? Look at all the standards in that topic area and which are vital public health activities within each standard that must occur and must be funded. The product of this work will be a list of the "core" outcomes and deliverables for public health in each area of the Standards, for both LHJs and the State DOH. Distinguish "core" from categorical services.

- Establish basic costs for the core activities identified, by Standard. Describe a reasonable set of costs: Using the professional judgment of a group of veteran public administrators, what would it take to achieve these outcomes throughout the state and to sustain them over time? Use an FTE basis for the cost estimate and the four categories of local health jurisdiction types (RUCA) outlined in the Baseline evaluation, where needed, to scale the model. Consider the cost of initial response, surge capacity, and maintaining "core" public health.

- Aggregate the costs statewide for the Standards within a topic area. Any adjustments?

Testing Costs

- Look at DOH programs and LHJs that performed well in 2002. Interview them and see how they rate the model. Adequate? Under-resourced? How would they improve it?
- Look at the work done on cost drivers of public health as a tool to estimate some of the costs.
- Revise cost models as indicated.
- Scale the cost model estimate, using population served as a starting point for LHJs, acknowledging that the estimates may need to be adjusted for outliers.

Estimating the Gap

Calculate an estimate for total funds needed system-wide and subtract current resources to give the amount of additional resources needed (the "gap") to meet the standards. Consider how much compliance with the standards demonstrates performance, coupled with what it would take to deliver a “core” service very well. Ensure the estimate allows for flexibility to respond to public health priorities.

General Process Steps and Timeline for the Sub-Committee

- Describe this to the full committees of Finance and Standards (**February**)
- Meet with the Consultant and Subcommittee to build cost models (**March**)
- Meet with Joint Standards-Finance Committees (**April**)
- Refine, finalize estimates (**April**)
- Final report and recommendations to the PHIP Steering Committee (**May**)